CONSENT FOR MEDICAL TREATMENT FORM

I acknowledge that there are risks in any student Summer program. It is imperative that my child follow instructions of all supervision, communicate any possibility of illness and avoid acts of third parties not under the control of supervisors. I acknowledge that all risks cannot be prevented, and assume those beyond the control of the University staff. I will take responsibility to see that my child is prepared for all activities and is in good health for the duration of the workshop in order to minimize risks to my child or other participants.

In case of medical emergency, I understand that every attempt will be made to contact me, my family physician, or the emergency contact named below. However, in the event that I or my named contacts cannot be reached, I give my permission to the adults in charge of the Stetson University Saxophone Workshop to secure emergency medical treatment for my child through Memorial Hospital of West Volusia. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance.

Student Name (print) _______________________________________________________

Parent/Legal Guardian (print) ______________________________________________

Home Phone__________________________ Work Phone__________________________

Cell Phone_________________________

Emergency Contact ________________________________________________________________________ (other than parent/guardian)

Phone__________________________________________________________________________

Health Insurance Co.__________________________________________________________

Policy # and/or Group#________________________________________________________

Phone__________________________________________________________________________ Fax_____________________________________

Family Physician_________________________________________________________________

Phone________________________________ Fax_____________________________________

For your child’s comfort and safety, please indicate any special medical or behavioral conditions we should know about (allergies, medications, injuries or illnesses, etc.) In addition, please take this opportunity to share any other information about your child that would be helpful to our workshop staff.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
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Is it okay to give your child pain reliever tablets if they complain of headaches or other minor aches and pains?  _____YES  _____NO

If yes, preferred form: ____Tylenol  ____Ibuprofen

Will your child be requiring any prescribed medications during the week?  ____YES  ____NO

If yes, is it okay for your child to take care of their own medication dose?  ____YES  ____NO

If you checked “NO” a staff member must be provided with specific written and signed instructions for your child’s medication upon check-in.

All Emergency Treatment will be handled at:
Memorial Hospital of West Volusia
701 West Plymouth Avenue
Deland FL 32720
Phone: (386) 943-4670
Hotline: (386) 738-5433

Parent/Guardian Signature____________________________________________________

Date_____________________

---------------------(the bottom portion must be signed/stamped by a public notary)---------------------

State of Florida
County of ________________________
Sworn to and subscribed before me this ____ day of _______, (year), by ________________________.

______________________________
Signature of Notary

______________________________
Typed or printed name of notary
(SEAL)

Personally known _____
Produced Identification _____
Type of Identification Produced __________